STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXX
Petitioner **File No. 87102-001**
v

Blue Cross and Blue Shield of Michigan
Respondent
_____/

Issued and entered
This 8th day of February 2008
by Ken Ross
Acting Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On January 8, 2008, XXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it for external review on January 15, 2008.

The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on January 29, 2008.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM Individual Care Blue- A PPO health care benefits certificate (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

On March 14, 2007, the Petitioner underwent hysterectomy surgery at XXXX Medical

Center. BCBSM denied coverage for this care because it considered the procedure to be treatment of a pre-existing condition.

The Petitioner appealed BCBSM's failure to pay for her surgery. BCBSM held a managerial-level conference on November 1, 2007, and issued a final adverse determination dated November 15, 2007.

III
ISSUE

Is BCBSM required to pay for the Petitioner's March 14, 2007 surgery?

IV
ANALYSIS

Petitioner's Argument

The Petitioner says that she was unaware that she had a waiting period for pre-existing conditions. She contacted BCBSM on February 17, 2007, prior to her surgery, to see if it would be covered. She informed BCBSM that she was having a total abdominal hysterectomy with a diagnosis of menorrhagia (excessive bleeding). She says that BCBSM told her that the surgery was covered under her PPO benefit at 70%. BCBSM did not say anything about a waiting period or preexisting condition exclusion. The Petitioner was under the impression that BCBSM would pay 70% of the amount charged for her surgery.

The Petitioner argues that had she been aware that her surgery would be excluded as treatment of a pre-existing condition she would have tried to wait and have the surgery after the waiting period ended. The Petitioner believes that she was misinformed by BCBSM about the amount to be paid for her surgery and wants BCBSM to pay for this care.

BCBSM's Argument

BCBSM says that the certificate covers most benefits on the effective date of the contract. However, hospital and physician services for pre-existing conditions are not covered during the first 180 days of coverage, beginning on the enrollment date.

The Petitioner's effective date of coverage with BCBSM was November 1, 2006. This is also her enrollment date. Her surgery was on March 14, 2007, which was only four months later. This is within the 180 day waiting period for pre-existing conditions.

The certificate defines a preexisting condition as:

> A condition for which medical advice diagnosis, care or treatment was recommended or received within the 180-day period ending on the enrollment date.

BCBSM reviewed the Petitioner's medical records and determined that she had heavy bleeding and abnormal bleeding as far back as 2004. She also had doctor's office visits for this condition on December 22, 2004, October 10, 2006, and November 30, 2006. Based on this information BCBSM concluded that the Petitioner's March 14, 2007 hysterectomy was treatment of a preexisting condition and therefore, not a covered benefit under the certificate. Therefore, BCBSM believes that its denial of payment for this surgery was correct.

Commissioner's Review

The certificate describes how benefits are paid. It explains that treatment of preexisting conditions is not a covered benefit the first 180 days after the effective date of coverage. The Petitioner's BCBSM coverage was effective on November 1, 2006. The Petitioner's March 14, 2007 surgery was within this 180 day period.

BCBSM established that the Petitioner received treatment for abnormal bleeding on October 10, 2006, just prior to the effective date of her coverage. Therefore, this care was within 180 days prior to the effective date and makes her menorrhagia a preexisting condition according to the terms of the certificate. Since this condition was the reason for her hysterectomy, the surgery was treatment of a preexisting condition and therefore not a covered benefit.

The Petitioner believes that BCBSM misinformed her about what it would pay for her surgery. Under the PRIRA, the Commissioner's role is limited to determining whether a health plan has properly administered health care benefits under the terms and conditions of the applicable insurance contract and state law. The Commissioner cannot resolve the kind of factual dispute

described by the Petitioner because the PRIRA process lacks the hearing procedures necessary to make findings of fact based on oral statements.

The Commissioner finds that BCBSM has correctly applied the provisions of the Petitioner's certificate when it determined the Petitioner's March 14, 2007 surgery was treatment of a preexisting condition.

V
ORDER

BCBSM's final adverse determination of November 15, 2007, is upheld. BCBSM is not required to pay for the Petitioner's March 14, 2007 surgery since it was treatment of a preexisting condition and not a covered benefit under the certificate.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.